



APPLICATION INTAKE FORM


**MEDICAID
SUCCESS**

APPLICATION INTAKE

PRIMARY CONTACT INFORMATION

Date	File No.
Name	
Phone	E-mail
Primary Contact Status <input type="checkbox"/> Spouse <input type="checkbox"/> Agent Under Power of Attorney <input type="checkbox"/> Court Appointed Guardian/Conservator <input type="checkbox"/> Other	

This form is extremely important. Your accuracy and completeness in responding will help us best provide the proper direction to help meet your concerns. All information provided on this form is considered personal and confidential and will not be shared without your permission.

CLIENT INFORMATION

Name		
Date of Birth (month,day,year)	Social Security Number	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married with Community Spouse <input type="checkbox"/> Married with Facility Spouse <input type="checkbox"/> Widowed <input type="checkbox"/> Separated		
Spouse Name (if applicable)		
Spouse Date of Birth (month,day,year) (if applicable)	Spouse Social Security Number (if applicable)	
Resident Address (prior to entering LTC facility)	State	Zip Code
Veteran Status <input type="checkbox"/> Veteran <input type="checkbox"/> Spouse of Veteran <input type="checkbox"/> Widow/Widower of Veteran		US Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No

FACILITY INFORMATION

Facility Name		
Phone Number		
Facility Address	State	Zip Code
Admission Date	Monthly Cost	

MONTHLY INCOME

Income Type	Client Monthly Income	Spouse Monthly Income
Social Security Benefits (Include Medicare Part B Deduction)		
Retirement Benefits (Gross)		
VA Disability Benefit		
Annuity Income		
Rental Income		
Other Income		
TOTAL MONTHLY INCOME		

NON-SHELTER LIVING EXPENSES

Expense Type	Amount	Frequency (monthly, yearly, or quarterly)
Medical (Includes nursing home or assisted living)		
Life Insurance Premiums		
Health Insurance Premiums		

GIFTS

Have you made gifts to a trust, an individual, or group of individuals, within the past 60 months?

☐ Yes

☐ No

If yes, please list gifts below

Recipient	Date	Amount
Recipient	Date	Amount
Recipient	Date	Amount

Have you ever filed a Federal Gift Tax Return?

☐ Yes

☐ No

TAXES

Does the applicant/spouse expect to file taxes?

☐ Yes

☐ No

ASSET

ASSETS	CLIENT	SPOUSE	JOINT
PERSONAL EFFECTS			
AUTOMOBILE			
CHECKING (Bank Name and Acct #)			
SAVINGS (Bank Name and Acct #)			
MONEY MARKET (Bank Name and Acct #)			
CERTIFICATES OF DEPOSIT (Bank Name and Acct #)			
RESIDENCE (ASSESSED VALUE)			
OTHER REAL ESTATE			

ASSET (CONTINUED)

ASSETS	CLIENT	SPOUSE	JOINT
BROKERAGE/CAP ACCOUNTS (Bank Name & Acct #)			
MUTUAL FUNDS (Bank Name & Acct #)			
STOCKS (Holding Company, # of Shares, Cost/Share)			
BONDS (Holding Company, Bond Value)			
ANNUITIES (Company Name)			
CASH VALUE - LIFE INSURANCE (Company Name)			
TRADITIONAL IRA/ RETIREMENT PLANS			
ROTH IRA			
NURSING HOME DEPOSIT			
CONTINUING CARE CONTRACT DEPOSIT			
PREPAID FUNERAL			
OTHER			
TOTALS			

HEALTH INFORMATION

Health of Husband (include current diagnosis)

Where Husband Currently Resides

Type of Care Provided

☐ None

☐ Home Care

☐ Assisted Living

☐ Skilled Nursing Facility

Amount of Time in Current Location

Health of Wife (include current diagnosis)

Where Wife Currently Resides

Type of Care Provided

☐ None

☐ Home Care

☐ Assisted Living

☐ Skilled Nursing Facility

Amount of Time in Current Location

If Either Spouse is in a Nursing Home, Does the Nursing Home Accept Medicaid Payments?

☐ Yes

☐ No

PHYSICIAN INFORMATION

Full Name of Husband's Primary Physician

Street Address

City

State

Zip Code

Full Name of Wife's Primary Physician

Street Address

City

State

Zip Code

PHARMACEUTICAL PLANS

If you are a Veteran, are you currently receiving prescription benefits from the Veteran's Administration?

☐ Yes

☐ No

CHILDREN

Name of Child		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Street Address		State	Zip Code
Phone		E-mail	
Date of Birth		Social Security Number	
Relationship to Husband <input type="checkbox"/> Natural child <input type="checkbox"/> Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Child born out of wedlock			
Relationship to Wife <input type="checkbox"/> Natural child <input type="checkbox"/> Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Child born out of wedlock			
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced			Children
Name of Child		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Street Address		State	Zip Code
Phone		E-mail	
Date of Birth		Social Security Number	
Relationship to Husband <input type="checkbox"/> Natural child <input type="checkbox"/> Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Child born out of wedlock			
Relationship to Wife <input type="checkbox"/> Natural child <input type="checkbox"/> Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Child born out of wedlock			
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced			Children
Name of Child		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Street Address		State	Zip Code
Phone		E-mail	
Date of Birth		Social Security Number	
Relationship to Husband <input type="checkbox"/> Natural child <input type="checkbox"/> Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Child born out of wedlock			
Relationship to Wife <input type="checkbox"/> Natural child <input type="checkbox"/> Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Child born out of wedlock			
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced			Children

CHILDREN (CONTINUED)

THE FOLLOWING QUESTIONS APPLY TO ALL CHILDREN LISTED IN THIS INTAKE FORM

Are all of your children in good health? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are any of your children blind or disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are any of your children receiving SSI or other forms of government benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, how much is monthly payment?	
Do any of your immediate family members have any problems with:			
AIDS? <input type="checkbox"/> Yes <input type="checkbox"/> No		Drug Addiction? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Alcoholism? <input type="checkbox"/> Yes <input type="checkbox"/> No		Spendthrift (debt problems or tax liens)? Yes No	
Do any of your children live with you in your home? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, name of child(ren)	
Are you a contributor to a 529 plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you a trustee of an UGMA Account? <input type="checkbox"/> Yes <input type="checkbox"/> No	

INTAKE SUBMISSION

WAYS TO SUBMIT

Email: info@medicaidsuccess.com

Fax: 888-742-4711

Mail: 24600 Center Ridge Rd., Ste. 270
Westlake, OH 44145



HAVE A QUESTION? **CALL US TODAY**

888-615-6144

www.medicaidsuccess.com